The Population Council in Bangladesh engaged in population policy research for the past two years. The purpose of the research was two-fold: to examine new and essential areas of interest to the national family planning program and to create an opportunity for young researchers to gain experience in all aspects of the implementation of policy research. The culmination of the program was a dissemination seminar held on 27 May in Dhaka. The seminar was attended by national program policy makers, program managers, service providers, fellow researchers from several organizations, and donor representatives. The preliminary results and policy implications of five studies were presented.

The Additional Secretary of the Ministry of Health and Family Welfare, Mr. Nurul Abedin was the Special Guest for the Opening Session and spoke on the occasion. He commented on the timeliness of this policy research to further the reproductive health agenda. He noted that each study was of significant current policy interest to program planners.

Dr. Kim Streatfield, Country Representative for the Population Council shared the purpose and objectives of the policy project. He mentioned that USAID, which funded the project, and the Population Council considered the further development of policy research capacity in Bangladesh essential. He noted that each researcher would be presenting studies done in collaboration with other groups in Dhaka and that the researchers, with the guidance of mentors in the Population Council office, had been responsible for every stage of their research work.

Following the presentations of each study, a panel was conducted where salient policy issues were highlighted. This panel included the chair of each study sesson: Dr. A. J. Faisel, Dr. Nancy Gerein and Dr. Mahmud Khan. David Piet the Director of USAID's Health and Population Office, was the day's Special Guest and moderated the panel. He stressed the necessity for continued policy research which focuses especially on the needs of clients for reproductive health services.

This Policy Dialogue highlights the policy implications of each study. The full reports will be available from the Population Council's office by mid-July.

STRENGTHENING STD SERVICES FOR MEN: AN URBAN CLINIC-BASED PROGRAM

Syeda Nahid M. Chowdhury, J. Victor Gomes, Sharif Md. I. Hossain

The Population Council (PC) conducted this intervention research in collaboration with the Marie Stopes Clinic Society (MSC). MSC has two urban-based clinics in Dhaka where male reproductive health services are offered. These clinics, located on Elephant Road and in Moakhali, were established in 1996 and reached 1467 men during the 9-month research period.

As part of the intervention research, a client health record form was developed and computerized. These records include: presenting complaint; previous medical history; clinical diagnosis; sexual history; and, where required for STD clients, partner management.
PC worked with MSC to increase the knowledge and skills of the clinic staff to serve STD clients.

The teams for the MSC and RTI studies present their findings.

The interventions included the development of IEC materials for clinic and community-based MSC staff to use for health education. A leaflet, "Are You at Risk?" and two flipcharts , "Sexual Health and Us" and "Sexually Transmitted Diseases" were prepared. These are the first IEC materials developed in Bangladesh on sexual health. A workshop for the field and clinic staff was also conducted by the research staff. The content of the workshop was sexual health and communication.

During the nine months of data collection, 1689 services were provided to the 1467 clients. Of all the men who attended the clinic, 11 percent were diagnosed with STDs. The majority of STD clients were between the ages of 20-29 and had no education. Another prominent problem was psychosexual. One-fourth of the total clients came for services for psychosexual disorders.

These are best described as "performance anxiety", lack of confidence in virility or masculinity, or problems related directly to coitus -- premature ejaculation or duration of erection. One-fourth of the clients were not monogamous but had sexual experience with commercial sex workers or other partners. When they went to other sexual partners, only 6 percent ever used condoms.

Though the data from these clinics are not generalizable, there are important policy implications for any organization which wants to start a clinic for men.

- An effective male STD intervention will have to target all age groups, employment categories and education levels.
- Personal contact appears to be a positive approach for reaching men seeking STD services. The field coordinators of MSC were very effective in reaching men in factories, slums and the bus station, particularly when

they began to use the IEC materials created for the intervention research.

- Exposure history is difficult to obtain, even from men who are infected with an STD and even when the service provider is technically skilled. Thus, it cannot be the only screening criteria especially since most men try to conceal this information. Extensive training of service providers is required to elicit complete client information.
- Male STD interventions should be coupled with general and other sexual health services as 50 percent of the STD diagnoses came from these two client categories.
- STD services for men require a two-pronged approach: 1) Intensive efforts to educate men about risks; and, 2) training for providers on sexuality and managing STD cases. ■

OPPORTUNITIES FOR INTEGRATION OF RTI/STD SERVICES IN MCH-FP PROGRAM

Syeda Nahid M. Chowdhury, Ismat Bhuiya, Sk. Najmul Huda, A.J. Faisel

PC collaborated with AVSC International in Bangladesh and AITAM to conduct this study in Dhaka District. It identified current RTI/STD services and interventions in 45 national family planning and MCH service delivery points (SDPs) of both GoB and NGOs. Data was collected in several ways: clients were interviewed prior to service; services were observed; facilities inventoried; and interviews and focus group discussions conducted with service providers, both clinic and field-based.

Seventy-seven percent of clients reported RTI symptoms during their pre-service interview but most did not report their complaints to the providers during service. Providers seldom obtained a comprehensive reproductive health history, often missing opportunities to diagnosis and treat clients.

Routine pelvic examination was performed on 58 percent of all new family planning acceptors. Almost all IUD acceptors, but only 51 percent of other clinical contraceptive acceptors, received a complete pelvic examination.

Among the clients who came for family planning follow up and side effects only 41 percent received a pelvic examination. Most concerning were clients who came with general reproductive health complaints. Though all had self-described symptoms of RTIs none were given a pelvic examination.

The quality of pelvic examinations varied widely. Most providers did not follow all the steps correctly. Inattention to essential steps allows transmission of infection and existing reproductive health problems can be both exacerbated and overlooked.

Dr. Yasmin Ahmed from MSC posing a question.

Examination of the facilities showed that most had the necessary space, equipment, and supplies to conduct routine RTI services. Most providers had training on family planning and MR, as well as some orientation on RTIs as part of these trainings. The majority understood the

The panel for the traditional family planning study.

relationship between RTIs in women and risks associated with infected partners. Yet, in spite of these positive findings, appropriate RTI services were rarely offered.

There are several policy implications from this research:

- Women do recognize the problems of RTIs and expect services from the SDPs. Their health seeking behavior for family planning and MCH services does provide an opportunity to address their RTI problems. Providers need to be proactive in utilizing the opportunities effectively. The policy challenge is to change providers attitudes and improve their skills in dealing with clients on their RTI conditions.
- Basic building blocks for RTI services are present in the system. The service delivery protocol can be revised so that each contact is used as an opportunity and client-provider contact can be maximized.
- Competency-based supervision and support is required to ensure quality of services.
- Existing training programs can be utilized to orient providers on the inter-link between RTIs and the other reproductive health services. ■

TRADITIONAL FAMILY PLANNING IN BANGLADESH

Alan Gray, Jamil H. Chowdhury, Bruce Caldwell, and Ahmed Al-Sabir

This study was conducted by PC and NIPORT in collaboration with ICDDR,B's Health and Family Planning Extension Project, Rural. The field study was undertaken by Associates for Community and Population Research (ACPR).
Traditional method use has continued to important in the Bangladesh program throughout its history. Seven to eight percent of couples continue to rely on the traditional methods of safe period, withdrawal, and to a lesser extent, kabiraji methods, to control their fertility.

While apparent method failure is high with use of the traditional methods, method continuation is in the long term as good as or better than method continuation with the main program methods. This is because many of the users of the main program methods in Bangladesh discontinue use due to side effects or health concerns, without immediately adopting another method. The majority of these women then become pregnant without resuming a method.

Analysis of interviews from the field study indicated that many women and men believe that use of hormonal methods, particularly the oral pill, can impair reproductive capacity permanently or else cause delivery complications. This belief is a significant determinant of opposition to the use of program methods before the birth of the first child, and to some extent to the use of methods while a couple still want more children. Traditional method use is relatively high before the birth of the first child.
The safe period method and withdrawal are so often used in conjunction with condoms that it is

difficult to refer to them as distinct methods.

The study found a number of cases where all three methods (safe period, withdrawal and condom) were in use, and the majority of users of any of these methods also used another.

Inconsistent accounts of method use by men and women are usually explicable by the fact that one or both of them are referring to only one aspect of what they normally do each month.

Failures with use of withdrawal have the evident simple explanation (ejaculation before withdrawal), failures of safe period method are mainly caused by having wrong or only partly complete information about the method. Most people do not just have a poor knowledge, they do not really know what the method is or the physiological basis for its use. Yet in the 1993-94 DHS it was the second most widely used temporary method exceeded only by oral pill.

The main policy implication of the findings concern whether information about basic reproductive physiology (characteristics of menstrual cycle, timing of ovulation, and at-risk period) should be disseminated through the family planning program. While this would give information to women and men which could be used to employ the safe period method more effectively, it would also benefit users of other temporary methods by informing them of the times during the cycle when intercourse would be particularly risky in case of method failure or unavailability of contraceptive supplies. ■

Dr. Nancy Gerein making a point during the adolescent study presentation

STUDY OF ADOLESCENTS: DYNAMICS OF PERCEPTION, ATTITUDE, KNOWLEDGE AND USE OF REPRODUCTIVE HEALTH CARE

Syed Jahangeer Haider, Shamsun Nehar Saleh, Nahid Kamal

This study, conducted by Research Evaluation Association for Development (READ) and Population Council assessed the knowledge, attitude and practices of sexual/reproductive health of married and unmarried adolescents aged 15-19. The objective was to identify the gaps where interventions may be needed to improve their reproductive health. Both qualitative (focus group discussion and in-depth interview) and quantitative (semi-structured questionnaire) were used in the study on a sample of 2100 adolescents. Where appropriate, the husband of married adolescents, and guardians, service providers and community leaders were also interviewed. The topics studied included: primary health care, sexuality, ideal age at marriage, reproductive health care, family planning, women's empowerment, violence against women, smoking and drug addiction.

The study results revealed that knowledge on basic MCH issues was not optimal. While knowledge of treatment for diarrhea and night blindness is universal, that on EPI vaccination is poor. Among adolescent mothers, the coverage of full dose EPI vaccines is less than half for all socio-economic groups interviewed. Only 22 percent of the rural poor and 27 percent of urban slum adolescent mothers availed of trained care (TBA and medical care) compared with 45 percent of urban colony dwellers during delivery. However between 30 and 70 percent of these young mothers said that they would like to use professional medical services during delivery. The contraceptive prevalence rate is considerably lower among the urban slum and rural poor, 31 and 36 percent respectively, compared with a CPR of 63 percent among the urban colony dwellers.

Dr. Sabera Rahman from MFSTC raises an issue.

Unmarried, as well as married adolescents advocate later age at marriage and want to delay the first birth. In general, the level of knowledge of RTI/STI/HIV was poor among all categories of male and female adolescents. There was also marked variation in the levels of knowledge by geographical and socio-economic classifications. The rural well-off seem to be the most well-informed and the city slum dwellers the least, on all sexual and reproductive health issues.

There were varied responses when asked what should be the medium for sex education. The unmarried female adolescents seem to prefer institutions like school, the married female would like mass media or a relative, and the category of unmarried male said that both institutions and the media are the ideal sources for sex education.

Some of the policy implications are:

- MCH component of the national program should target the adolescent mothers as a high risk group with special needs. Adolescent mothers need education/information on EPI, breastfeeding and FP use, and access to quality care during delivery.

- There seems to be a big gap between the actual and desired ages at marriage and first birth among unmarried as well as married adolescents. Viable social and economic options have to be created so that they may fulfil their marriage and fertility goals.

- The low level of knowledge on all health issues, particularly those of reproductive health and sexuality, indicates that systematic education is required. The policy challenge is to determine how and where to reach adolescents, in culturally sensitive ways, to increase their knowledge. The use of both formal and non-formal education, as well as the use of the mass media all need exploration.■

INCREASING THE FINANCIAL SUSTAINABILITY OF FAMILY PLANNING SERVICE DELIVERY IN BANGLADESH

Kim Streatfield, Sayyied Kabir, Kanta Jamil, Barbara Janowitz, Naushad Faiz

While the national family planning program in Bangladesh has been successful, CPR has to reach 68 percent in order to achieve replacement level by the target of 2005. This means that 22 million couples will have to use family planning methods which is double the current number. More resources will be needed to sustain and strengthen the program into the next decade. There is a growing concern that the resources available for funding the program will be increasingly inadequate to cover its costs. So, more cost-effective methods of service delivery need to be implemented and ways of mobilizing additional resources found. This study examined the feasibility of increasing the financial sustainability of the national program by reducing its net costs.

The team for the costing study responding to question

The study sampled oral pill and injectable users (total of 2590) from both high and low performing areas of rural Bangladesh, and from the slum populace of Dhaka city. For the rural areas, the users were taken approximately equally from GoB and NGO programs.

Recognizing the differences in user needs and in program objectives, however, the study incorporated alternative strategies for examining the feasibility of financial sustainability among the various groups of urban and rural pill and injectable users. For rural pill users, the largest and most important group, the particular approach was to use pricing strategies to both induce a modification of the service delivery system and generate revenue from home delivery.

In the GoB program area, where clients do not pay, a system of differential pricing was used whereby users could receive the current service free of charge at static or satellite clinics, but would have to pay to continue to receive them at home. The study findings indicated that if the GoB attached a price of 1 Taka for home delivery of a month's cycle of pills, about half of the couples currently receiving their pills at home would go to a clinic to obtain them. If the price for home delivery was 5 Taka, about 80 percent would go to a clinic.

In the NGO areas where most users are currently being asked to pay between 0.50 and 2 Taka (average was 1 Taka) for a cycle of pills, the system of differential pricing involved increasing the price for home delivery while keeping it pattern to the GoB areas was observed. The study found that if the price of pills delivered at home was raised 2 Taka above current levels then over half would go to a clinic. If the price was raised by 4 Taka then this proportion increased to three-quarters.

Quite importantly, for both GoB and NGO areas, virtually no current pill user indicated that she would stop using a modern contraceptive in response to a price change. A very small proportion (about 1 percent) would switch methods. Further analysis revealed that for the GoB areas at least, socio-economic factors as well as mobility and accessibility to clinics were important determinants in the user's choice of

source when pricing was introduced. Not surprisingly, it was the relatively well-off, more educated and less mobile users with poor access to clinics who were more inclined to pay for pills at home.

An important issue, when considering imposing prices for GoB FP services previously provided free, is equity. The GoB program must find ways to continue to be accessible to the poor even when charging prices for its services. Examining the NGO program's deferred payment policy which is designed to ensure that couples with inadequate funds or insufficient cash can receive supplies without appearing to get them for free, the study found that a quarter of all pill users currently receiving supplies at home do so on credit. Since revenue will theoretically be recovered from these users later, it clearly has heavy administrative cost implications for the program. However, if everyone had to pay at the time of pill supply, the study found that over 95 percent would comply and get the pills at home. Thus, clearly the present policy is being overused.

The main policy implications of these findings are that setting differential prices can encourage couples to seek services outside the home, where the percentage encouraged to go out will depend on the actual differential in prices. The reduction in the burden on the fieldworkers that this implies, however, must be balanced against the increased burden on the clinics. Also, while there is potential for cost recovery without sacrificing equity, the current NGO experience shows that deferred payment may neither be the most efficient nor the most cost-effective strategy for achieving this goal. A simpler, administratively less burdensome alternative is clearly needed. ■

The panel members summarize the policy conclusions.

This Policy Dialogue was prepared by The Population Council, Bangladesh.
Office Address: House CES(B) 21, Road 118, Gulshan, Dhaka 1212, Bangladesh.
Telephone: 880-2-886657/881227
Fax: 880-2-883127/883132
Email:PCDHAKA@POPCOUNCIL.ORG.
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